MARYLAND STATE DEPARTMENT OF HEALTH

06584

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

6539

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY Charles — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata — LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
SARAH	E	BIVENS	7	6	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	C	W	12-10-30	24 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
?	SARAH BIVENS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
981X Immediate cause	(a) INTRA PLEURAL HEMORRHAGE	7-6-55
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pistol Shots in Chest	7-6-55
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0		Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	Home	La Plata	Charles	Md

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐	Not while at work ☑	HOW DID INJURY OCCUR?
7	6	55	7 P m.			Shot by common law Husband

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. Medellin	M.D.	La Plata Md	7-7-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	July 9 1955	Sacred Heart	Leonardtown	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-9-55	Julia H. Posey	Barnhart Funeral Home Inc	La Plata Md.

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07678

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

6531

Reg. Dist. No. 106

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Indian Head — LENGTH OF STAY (In this place) 8 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8 Olson Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Chas
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North East. 07X-2
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Martha (Middle) Danielle (Last) Blevins
4. DATE OF DEATH: (Month) July (Day) 19 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 2/22/54
9. AGE last birthday: one yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Havre de Grace Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Ira B Blevins
14. MOTHER'S MAIDEN NAME: Hester Ole Phipps
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Mrs. O.L. Bullock 8 Olson Rd.

18. MEDICAL CERTIFICATION — Indian Head Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
924.0
Immediate cause (a) Strangulation as a result of falling — Interval Between Onset and Death: Unknown
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Entrapment (unknown) by bed-wall
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No X

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. X
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home
(CITY OR TOWN) Indian Head (COUNTY) Charles (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): 7- 19-55 1 p.m.
INJURY OCCURRED While at work ☐ Not while at work X
HOW DID INJURY OCCUR? Fell off from bed (dust storm) & suffocated.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident X suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Thant G. Dyson M.D. (Degree or title) ADDRESS: Indian Head. Md. DATE SIGNED: 7-19-55

23. BURIAL, CREMATION, REMOVAL (Specify): Buried
DATE THEREOF: 7/ /55
NAME OF CEMETERY OR CREMATORY: Pitcher Chapel
LOCATION (City, town, or county) (State): North East Md.
DATE REC'D BY LOCAL REG.: 7/19/55
REGISTRAR'S SIGNATURE: Odey Price
24. FUNERAL DIRECTOR: Gude Funeral Home ADDRESS: No. East Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

06585

6532

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Charles — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata Rfd. X
STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED (Type or Print): (First) Willie (Middle) B (Last) Bowman
4. DATE OF DEATH: (Month) 7 (Day) 5 (Year) 1955
5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M
8. DATE OF BIRTH: 5-5-05
9. AGE last birthday: 50 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY: U S
13. FATHER'S NAME: Wm Bowman
14. MOTHER'S MAIDEN NAME: Lizzie Holt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Nancy Barber La Plata Rfd

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

812X
Immediate cause (a) CRUSHED CHEST — 7-5-55

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. COMPOUND FRAC BOTH LEGS — 7-5-55

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Hwy 301 — (CITY OR TOWN) La Plata — (COUNTY) Charles — (STATE) Md
TIME OF INJURY (Month) 7 (Day) 5 (Year) 55 (Hour) 2:30 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Hit By Auto

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS — DATE SIGNED
C. Medellin M.D. La Plata Md 7-7-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF July 8 1955 — NAME OF CEMETERY OR CREMATORY Sacred Heart — LOCATION (City, town, or county) (State) Laplata md.
DATE RECEIVED BY LOCAL REG. 7/7/55 — REGISTRAR'S SIGNATURE Julia H. Posey
24. FUNERAL DIRECTOR — ADDRESS: Orchard Funeral Home Inc Laplata md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06586

6583

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Faulkner
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Faulkner
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) Adrian (Last) BURCH

4. DATE OF DEATH: (Month) July (Day) 22 (Year) 1955

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): M.

8. DATE OF BIRTH: Dec. 23, 1878

9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: George Burch

14. MOTHER'S MAIDEN NAME: Mary Catherine Dean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: George E. Burch, Faulkner

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
442X IMMEDIATE CAUSE	(A) Respiratory failure,	2 days
ANTECEDENT CAUSE ($)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Cardiovascular disease	4 yrs.
	DUE TO	
	(C) Arteriosclerosis, renal impairment.	5 years.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1950, to 22 July, 1955, that I last saw the deceased alive on 21 July, 1955, and that death occurred at 2:15 EST M, from the causes and on the date stated above.

SIGNATURE J. Woodd, M. D. ADDRESS La Plata. Md. DATE SIGNED 22 July 55

23. BURIAL, CREMATION, REMOVAL, (SPECIFY) Burial DATE THEREOF? 7/25/55 NAME OF CEMETERY OR CREMATORY St. Josephs LOCATION (City, town, or county) (State) Morganza Md.

DATE REC'D BY LOCAL REGISTRAR 7/22/55 REGISTRAR'S SIGNATURE Julia A. Casey

24. FUNERAL DIRECTOR Mattingly Funeral Home ADDRESS Leonardtown Md.

MARYLAND STATE DEPARTMENT OF HEALTH

06587

6584

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING — Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Benedict — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. — COUNTY 47K-3
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 1148 Oates St N.E.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	William		Gibbs	July	5	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	C	Married	Feb 29 1916	39 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Car Clean	Railroad	N.C	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Herman Gibbs	Sarah Henry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	[illegible]	James Barnes Washington

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning — 7-5-55

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) [illegible]

(c) [illegible]

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Swimming

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	Patuxent River	Charles		Md

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
7	5	55	P.M.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. Edelen	M.D.	LaPlata Md	7-6-55

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	7-6-55		Washington	D.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-9-55	Julia L. Casey	Hoatt & Ryan	Waldorf Md

VS. A16A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06588

6535

CERTIFICATE OF DEATH

Reg. Dist. No. 141

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pisgah
LENGTH OF STAY (in this place): 80 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pisgah
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (First) Rachel (Middle) Ankes (Last) Ross Greer (Type or Print)

4. DATE OF DEATH: (Month) July (Day) 1 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 17 1874

9. AGE last birthday: 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pisgah Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Ross

14. MOTHER'S MAIDEN NAME: Sarah Ankes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: John Greer Indianhead Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	2 wks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Hypertensive Heart Disease	3 years
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/21 19 55, to 7/1 19 55, that I last saw the deceased alive on 7/1 19 55, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Smith Susan M.D. ADDRESS Indianhead Md DATE SIGNED 7-1-55

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF 7-4-55

NAME OF CEMETERY OR CREMATORY Smith Chapel

LOCATION (City, town, or county) Pisgah (State) Md

DATE REC'D BY LOCAL REG. 7/3/55

REGISTRAR'S SIGNATURE Mary Southerland

24. FUNERAL DIRECTOR Penny-Cofer—Mason Springs ADDRESS

06589

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6586 **CERTIFICATE OF DEATH** Reg. Dist. No 100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Charles MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Charles; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Longhaville; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) HARRY (Middle) B (Last) HANDLEY

4. DATE OF DEATH: (Month) July (Day) 15 (Year) 1955

5. SEX: M. 6. COLOR OR RACE: W. 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): M. 8. DATE OF BIRTH: Feb. 2, 1885 9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer-Retired 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Md. 12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Harry B. Handley 14. MOTHER'S MAIDEN NAME: Clora Reider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS: Clarice Handley, Longhaville Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

442X IMMEDIATE CAUSE (A) CARDIO-VASCULAR RENAL — 4-1954

ANTECEDENT CAUSE (S) DUE TO (B) FAILURE

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Gen. Art. Sclerosis — 1953

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-1, 1955, to 7-15, 1955, that I last saw the deceased alive on 7-15 1955, and that death occurred at 1P M, from the causes and on the date stated above.

SIGNATURE E. Edelen M.D. ADDRESS LaPlata Md DATE SIGNED 7-15-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF 7/18/55 NAME OF CEMETERY OR CREMATORY St. Ignatius LOCATION (City, town, or county) (State) Bel Alton, Md

DATE REC'D BY LOCAL REGISTRAR 7/18/55 REGISTRAR'S SIGNATURE Julia H. Posey 24. FUNERAL DIRECTOR Arehart Funeral Home ADDRESS LaPlata, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06590

6597 CERTIFICATE OF DEATH

Reg. Dist. No. 108

1. PLACE OF DEATH: COUNTY Charles MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plato, Md.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6th Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf. X
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED: (Type or Print) (First) — (Middle) — (Last) HARRISON

4. DATE OF DEATH: (Month) July (Day) 23 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): | 8. DATE OF BIRTH: July 23, 1955 | 9. AGE last birthday — yrs. | IF UNDER 1 YEAR: Months — Days — | IF UNDER 24 HRS.: Hours — Min. 2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S. of America

13. FATHER'S NAME: George W. Harrison Jr.
14. MOTHER'S MAIDEN NAME: Ruby Streland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT & ADDRESS: Father.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

761.0 IMMEDIATE CAUSE (A) Difficult Labor - Left Footling Breech Presentation

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Large Baby
(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 23, 1955 to ....., 19....., that I last saw the deceased alive on July 23, 1955, and that death occurred at 9:57 A M, (EST) from the causes and on the date stated above.

SIGNATURE Jakob M Lerner M. D. ADDRESS DATE SIGNED July 24, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 7/24/55
NAME OF CEMETERY OR CREMATORY Family Plot
LOCATION (City, town, or county) (State) Waldorf Md

DATE REC'D BY LOCAL REGISTRAR 7/24/55
REGISTRAR'S SIGNATURE Julia H Posey
24. FUNERAL DIRECTOR Leo W. Harrison, ADDRESS Waldorf, Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

20752611377

Mrs Wills Posey Sr

MARYLAND STATE DEPARTMENT OF HEALTH

06591

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indianhead Rd — LENGTH OF STAY (In this place) en route
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indianhead Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	JAMES	WILLIAM	HENRY		July	1	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	C		2-11-40	15 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Baltimore Md	

13. FATHER'S NAME Walter Henry — 14. MOTHER'S MAIDEN NAME Frances Posey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT AND ADDRESS Minnie P Henry Indianhead

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

929.8

Immediate cause (a) Drowning — Interval between onset and death: 7-1-55

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	Potomac River		Chas	Md

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐	Not while at work ☐	HOW DID INJURY OCCUR?
7	1	55	4 p.m.			Riding life preserver in pool

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE C Madden (Degree or title) MD — ADDRESS La Plata Md — DATE SIGNED 7-3-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	July 3, 55		Washington	DC

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7/3/55	Julia H Davey	Gilbert Funeral Home	La Plata Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

6589

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 06592

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Charles — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X — LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Wicomico River

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Charles

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Tompkinsville

STREET ADDRESS (If rural, give location) /

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day)	(Year)
FRANCIS	PATRICK	HILL	July 6	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	Colored	S	March 17 1941	14 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Julian Hill	De Coems

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
		Bernadine Hill 1839 Kalorama Rd NW DC

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
7548 Immediate cause	(a)	Drowning	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)		
	DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY River	21c. (City or town)	(County)	(State)
		Tompkinsville	Charles	Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY July 6 1955 M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
		Found drowned

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED 7/7/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-9-55	Holy Heart	Reisterstown Md

DATE REC'D BY LOCAL REG 7-9-55	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
	Julia F. Posey	Earhart Funeral Home Inc	Fairfax Va.

VS. A15A - 5 - 53

6590

06593

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Charles MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf (Rural)

LENGTH OF STAY (in this place) —

HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Charles

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Waldorf, Md.

STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED: (Type or Print) (First) BARBARA (Middle) [illegible] (Last) [illegible]

4. DATE OF DEATH (Month) 7/22/55 (Day) (Year) 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH: Aug 1954

9. AGE last birthday: 11 mos. yrs.

IF UNDER 1 YEAR: Months — Days —

IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): [illegible]

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: [illegible]

14. MOTHER'S MAIDEN NAME: Barbara Hurst

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) —

(If Yes, give war or dates of) —

16. SOCIAL SECURITY No.: [illegible]

17. INFORMANT & ADDRESS: [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) 046.9 Choriomeningitis — Interval Between Onset and Death: —

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO Virus infection - type undetermined not poliomyelitis — —

(c) —

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDING OF OPERATION: —

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY —

21c. (City or town) (County) (State) —

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. —

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR? —

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, ~~Homicide~~ ☐, Undetermined cause ☐.

SIGNATURE R T Fisher M. D.

CHIEF MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 7/22/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF July 24 1955

NAME OF CEMETERY OR CREMATORY [illegible]

LOCATION (City, town, or county) (State) Charles Co. Md.

DATE REC'D BY LOCAL REG. 7-23-55

REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR Hutt & Ryon

ADDRESS Waldorf Md.

VS. A15A - 5 - 53

20842034O4

MARYLAND STATE DEPARTMENT OF HEALTH

6591

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06594

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X La Plata — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 66 Jayne Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington — COUNTY DC
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 47 x 3
STREET ADDRESS (If rural, give location) 1640 Fort Davis St SE V

3. NAME OF DECEASED (Type or Print): (First) Ernest (Middle) Leroy (Last) Moore
4. DATE OF DEATH: (Month) July (Day) 21 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE Last Birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	Single	7-23-?	58 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Attendant	Gas Station	Marshall Co Miss	

13. FATHER'S NAME: John Moore
14. MOTHER'S MAIDEN NAME: Betty Crosley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
		Clifton Moore Brandywine Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) [illegible] Pneumonia	7-21-55
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Heart Clot	7-21-55
(c) Arteriosclerosis	7-21-55
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	[illegible]	[illegible]	Chas.	Md.

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐	Not while at work ☐	HOW DID INJURY OCCUR?
7/15	7-21-55		p.m.			Driver of car - hurt in collision truck

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE [illegible] (Degree or title) MD ADDRESS La Plata Md DATE SIGNED 7-22-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 23	Holy Springs	Holy Springs Miss

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7/23/55	Julia H Haney	Crehont Funeral Home Inc La Plata	Md.

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

06595

6592

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH — COUNTY: Charles — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: La Plata — LENGTH OF STAY in this place: today
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 88

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington — DC
STREET ADDRESS (If rural, give location): 5002 6th St NE. 16X-7. ✓

3. NAME OF DECEASED (Type or Print): (First) Peter (Middle) F (Last) St Clair

4. DATE OF DEATH: (Month) 7 (Day) 3 (Year) 55

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): | 8. DATE OF BIRTH: 4-13-18 | 9. AGE last birthday: 37 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpet Layer | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Amoys Co mnd | 12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Peter St Clair | 14. MOTHER'S MAIDEN NAME: Annie Owens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): | 16. SOCIAL SECURITY NO.: 579-01-4032 | 17. INFORMANT AND ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

816X

Immediate cause (a) Crushed Chest — 7-3-55

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Auto accident — 7-3-55

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: 301 | (CITY OR TOWN): Hi Jinks | (COUNTY): La Plata | (STATE): Charles Md

TIME OF INJURY (Month) (Day) (Year) (Hour): 7 3 55 7P | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? Truck - auto Collision

22. *I certify that I took charge of the remains described above, held an Autopsy __, Inspection ✓, Inquiry __ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ✓, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: C Hedelen (Degree or title) MD | ADDRESS: La Plata Md | DATE SIGNED: 7-3-55

23. BURIAL, CREMATION, REMOVAL (Specify): Removal | DATE THEREOF: July 3 55 | NAME OF CEMETERY OR CREMATORY: | LOCATION (City, town, or county) (State): Washington DC

DATE RECD BY LOCAL REG.: 7/6/55 | REGISTRAR'S SIGNATURE: Julia Hasey | 24. FUNERAL DIRECTOR: Gerhart Funeral Home Inc Laplata Md | ADDRESS:

VS. A16A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

06596

6593

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible] LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS [illegible]

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY [illegible]
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]
STREET ADDRESS (If rural, give location) [illegible]

3. NAME OF DECEASED (Type or Print): (First) [illegible] (Middle) [illegible] (Last) [illegible]

4. DATE OF DEATH: (Month) 7 (Day) [illegible] (Year) 19[illegible]

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	White	[illegible]	[illegible]	[illegible] yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
[illegible]	[illegible]	[illegible]	U.S.

13. FATHER'S NAME [illegible]

14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
[illegible]		[illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
33/X Immediate cause	(a) Cardiac failure	6 months
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) cerebrovascular accident	6 months
	(c) arteriosclerosis	10 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan 15, 19[illegible], to July, 19[illegible], that I last saw the deceased alive on July, 19[illegible], and that death occurred at [illegible] A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Frederick M. Hanson MD	[illegible]	July [illegible]

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
[illegible]	[illegible]	[illegible]	[illegible]

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-9-35	Julia A. Posey	[illegible]	[illegible]

06597

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6594

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY Charles MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 66 Physician Memorial

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf Md.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) LIZZIE (Middle) BELLE (Last) SOLLARS

4. DATE OF DEATH: (Month) 7 (Day) 9 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): W

8. DATE OF BIRTH: 11-26 1878

9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY: Self employed

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Burkins

14. MOTHER'S MAIDEN NAME: MARTHA MORRISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) None

17. INFORMANT & ADDRESS: Mrs Mabel Bateman, Waldorf Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH 7-9-55

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C) Senil ART Sclerosis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-4, 1955, to 7-4, 1955, that I last saw the deceased alive on 7-4, 1955, and that death occurred at 3:30 P M, from the causes and on the date stated above.

SIGNATURE E. Edelen M.D. ADDRESS La Plata Md DATE SIGNED 7-9-55

23. BURIAL, CREMATION REMOVAL (SPECIFY) Burial — DATE THEREOF 7/12/55 — NAME OF CEMETERY OR CREMATORY Mt. Rest. — LOCATION (City, town, or county) (State) La. Plata. Maryland

DATE REC'D BY LOCAL REGISTRAR 7/13/55 — REGISTRAR'S SIGNATURE Julia H Casey

24. FUNERAL DIRECTOR Hewitt + Ryon, — ADDRESS Waldorf, Md

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6593 06598

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plata
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Charles
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) ELIZABETH (Middle) (Last) STONE

4. DATE OF DEATH: (Month) July (Day) 30 (Year) 1955

5. SEX: F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S.

8. DATE OF BIRTH: Nov. 11, 1868

9. AGE last birthday 86 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas D. Stone

14. MOTHER'S MAIDEN NAME: Elizabeth J. Edelen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Mrs. Margaret Dippold Waldorf, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

434.3

IMMEDIATE CAUSE (A) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: instantaneous

ANTECEDENT CAUSE (B) OUE TO general debility — 6 Months

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) OUE TO old age — 10 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE OISEASE OR CONDITION CAUSING OEATH.

19A. DATE OF OPERATION: 0

19B. MAJOR FINOINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW OIO INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 19 54, to July, 19 55, that I last saw the deceased alive on 30 July, 19 55, and that death occurred at 6:05 P M, from the causes and on the date stated above.

SIGNATURE Frederick M. Johnson M. D. ADDRESS La Plata, Md. DATE SIGNED 30 July 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — OATE THEREOF Aug. 1, 1955 — NAME OF CEMETERY OR CREMATORY Family Burying Lot — LOCATION (City, town, or county) (State) Near Popes Creek, Md.

OATE REC'D BY LOCAL REGISTRAR 8/1/55 — REGISTRAR'S SIGNATURE Julia D Bosley

24. FUNERAL OIRECTOR Hunt & Ryon, Waldorf, Md. — AODRESS

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING